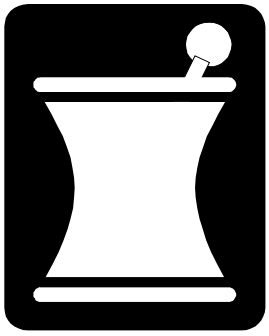
Pharmacy Provider Manual

For

Kentucky Medicaid

Administered By:
First Health Services Corporation
Richmond, Virginia
Effective
12/04/2004



11/12/2004

TABLE OF CONTENTS

Section 1: Introduction

Providers may begin submitting claims through First Health Services on December 4, 2004.

The Point-of-Sale (POS) system will require pharmacies to submit claims to First Health Services electronically in the National Council for Prescription Drug Programs (NCPDP) standardized Version 5.1; lower versions will not be accepted. After submission, First Health Services will respond to the pharmacy provider with information regarding recipient eligibility, Kentucky Medicaid's allowed amount, applicable Prospective Drug Utilization Review (ProDUR) messages, and applicable Rejection messages. ProDUR messages will be returned in the DUR response fields; other important related information will be displayed in the free form message area. It is of utmost importance that all providers see the appropriate messages exactly as First Health Services returns them.

In addition to POS claims, First Health Services will accept claims from approved providers via electronic batch on diskettes or through FTP. The format for electronic media is NCPDP Batch 1.1. Paper claims will also be accepted. In those cases where a paper claim is needed, First Health Services will require a Universal Claim Form (UCF). Approved providers may submit claims using directly to a web-based claim entry.

All arrangements with switching companies should be handled directly by the provider with their preferred switching company.

1.1 Important Telephone Numbers

Responsibility	Help Desk	Phone Numbers	Availability
Recipient Help Desk	**FHS/Technical Call Center**	800-432-7005	8:30 a.m. - 5:00 p.m., ET Monday - Friday
Prior Authorization Help Desk	**FHS/Managed Access Program Call Center**	800-477-3071 (voice)	24 hours
		800-365-8835 (fax: **NORMAL**)	24 hours
		800-421-9064 (fax: **URGENT**)	24 hours
		800-453-2273 (fax: **LTC**)	24 hours
Provider Help Desk	**FHS/Technical Call Center**	**800-432-7005**	24 hours
MAC Pricing	**FHS**	MAC price look-up: http://kentucky.fhsc.com To appeal MAC pricing: fax: 804-217-7911 or email: rebate@fhsc.com.	24 hours
Software Vendor Certification	**FHS**	804-217-5060 WilsonCA@fhsc.com	Carrie Wilson 9:00 a.m.- 5:00 p.m., ET Monday - Friday
Voice Response Eligibility Verification (VRSV) (Recipient Eligibility)	**KY**	800-807-1301	
Department for Medicaid Services (DMS) (Recipient Eligibility)	**KY**	502-564-5020	
Pharmacy Network Enrollment (Information)	**KY**	877-838-5085	
Provider Relations	**KY**	800-807-1232	
Universal Claim Forms or HCFA 1500 forms	**To request additional forms**	888-665-2600	Moore Documents
First Health Services Kentucky Medicaid Account Management	**FHS**	502 - 564-4321 x 3168 502 - 564-7940 x 3427	Kim Broyles, Pharm D. Amey Hugg, Pharm D. 9:00 a.m.- 5:00 p.m., ET Monday - Friday

1.2 Addresses

ADDRESS	FORMAT
Provider Paper Claims Billing Address: First Health Services Corporation Kentucky Medicaid Paper Claims Processing Unit P.O. Box C-85042 Richmond, VA 23261-5042	Universal Claim Form (UCF)
Diskette Claims Address: First Health Corporation Attn: Kentucky Media Control 4300 Cox Road Glen Allen, VA 23060	NCPDP Batch 1.1
FTP: First Health Services Corporation 804-290-8371 (fax forms)	NCPDP Batch 1.1
Direct Data Entry (Web) Carrie Wilson 804-217-5060 WilsonCA@fhsc.com	NCPDP version 5.1

Paper Claims Billing Instructions
See *Appendix A*: Universal Claim Form.

Website
http://www.chfs.ky.gov/dms/
http://kentucky.fhsc.com

Software Vendor

NOTE: Software vendors must be certified with First Health Services to submit NCPDP version 5.1. If you have any questions or need assistance in any way, please contact (804) 217-5060 or email Vendor_Certification@fhsc.com.

1.3 Service Support

On-line Certification
Effective December 4, 2004, any Kentucky Medicaid network provider who has a valid Kentucky Medicaid number may submit claims.

On-line System Not Available
If for any reason the on-line system is not available, providers should submit claims when the on-line capability resumes. To facilitate this process, the provider's software should have the capability to submit backdated claims.

Technical Problem Resolution
To resolve technical problems, providers should follow the steps outlined below:

1. Check the terminal and communications equipment to ensure that electrical power and telephone services are operational. Call the telephone number the modem is dialing and note the information heard (i.e. fast busy, steady busy, recorded message). Contact the software vendor if unable to access this information in the system.

2. If the pharmacy provider has an internal Technical Support Department, the provider should forward the problem to that department. The pharmacy's technical support staff will coordinate with First Health Services to resolve the problem.

3. If the pharmacy provider's network is experiencing technical problems, the pharmacy provider should contact the network's technical support area. The network's technical support staff will coordinate with First Health Services to resolve the problem.

4. If unable to resolve the problem after following the steps outlined above, the pharmacy provider should contact the First Health Services Technical Call Center at:

First Health Services Technical Call Center
1-800-432-7005
(Nationwide Toll Free Number)

Section 2: Program Setup

2.1 Claim Format

- Point-of-Sale claims must be submitted in the NCPDP version 5.1 format.
- Batch claims must be submitted in the NCPDP Batch 1.1. format.
- The Universal Claim Form (UCF) must be submitted for paper submissions. See *Appendix A* for sample UCF and instructions.

2.2 Media Options

- Point- of- Sale
- Direct data entry (web)
- Batch
- Provider submitted paper

2.3 Networks

- NDC (National Data Corporation)
- QS1
- WebMD (Envoy)

2.4 Transaction Types

The following transaction codes are defined according to the standards established by the NCPDP. Ability to use these transaction codes will depend on the pharmacy's software. At a minimum, all providers should have the capability to submit original claims (Transaction Code B1) and reversals (Transaction Code B2). Additionally First Health Services will also accept re-bill claims (Transaction Code B3).

Full Claims Adjudication (Transaction Code B1)
This transaction captures and processes the claim and returns to the pharmacy the dollar amount allowed under the Kentucky Medicaid reimbursement formula. B1 corresponds to the "01-04" Transactions supported by version 3.2/3C.

Claims Reversal (Transaction Code B2)
This transaction is used by the pharmacy to cancel a claim that was previously processed. To submit a reversal, the provider must void a claim that has received a **Paid** status. To reverse a claim, the provider selects the Reversal (Void) option in the pharmacy's computer system. B2 corresponds to the "11" Transaction supported by version 3.2/3C.

NOTE: The following fields must match on the original paid claim and on the void request for a successful claim reversal:

- Service Provider ID
- Prescription number
- Date of service (date filled)
- NDC

Claims Re-bill (Transaction Code B3)
This transaction is used by the pharmacy to adjust and resubmit a claim that has previously been processed and received a **Paid** status. A "claims re-bill" voids the original claim and resubmits the claim within a single transaction. B3 corresponds to the "31-34" Transactions supported by version 3.2/3C. A complete listing of all transactions supported in NCPDP version 5.1 is on the following page.

Eligibility Verification (Transaction Code E1)
This transaction is used by the pharmacy to determine a recipient's eligibility in the program. This transaction is rarely used as this information is provided as part of the claim transaction.

2.5 Version 5.1 Transactions

Please review the following for program requirements; some transactions may be required at a future date to be determined:

NCPDP Lower Version Transaction Code	NCPDP Lower Version Transaction Name	NCPDP Version 5.1 Transaction Code	NCPDP Version 5.1 Transaction Name	Transaction Support Requirements
00	Eligibility Verification	E1	Eligibility Verification	Supported <**12/04/2004**>.
01 - 04	Rx Billing	B1	Billing	Required <**12/04/2004**>.
11	Rx Reversal	B2	Reversal	Required <**12/04/2004**>.
21 - 24	Rx Downtime Billing	N/A	N/A	Not supported in version 5.1.
31 - 34	Rx Re-billing	B3	Re-bill	Required <**12/04/2004**>.
41	Prior Authorization Request with Request for Payment	P1	Prior Authorization Request and Billing	Not required.
45	Prior Authorization Inquiry	P3	Prior Authorization Inquiry	Not required.
46	Prior Authorization Reversal	P2	Prior Authorization Reversal	Not required.
51	Prior Authorization Request Only	P4	Prior Authorization Request Only	Not required.

2.6 Version 5.1 Segments

Data in NCPDP version 5.1 is grouped together in segments. Please review the following for program requirements; some segments may be required at a future date to be determined.

NCPDP Request Segment Matrix									**Segment Support Requirements**
Transaction Code	**E1**	**B1**	**B2**	**B3**	**P1**	**P2**	**P3**	**P4**	Some segments may be required at a future date to be determined.
Segment									
Header	M	M	M	M	M	M	M	M	Required **<12/04/2004>**.
Patient	S	S	S	S	S	S	S	S	Required **<12/04/2004>**.
Insurance	M	M	S	M	M	S	M	M	Required **<12/04/2004>**.
Claim	N	M	M	M	M	M	M	M	Required **<12/04/2004>**.
Pharmacy Provider	S	S	N	S	S	S	S	S	No planned requirements at this time; **may be required at a future date.**
Prescriber	N	S	N	S	S	S	S	S	Required **<12/04/2004>**.
COB/ Other Payments	N	S	N	S	S	N	S	S	Required **<12/04/2004>**.
Worker's Comp	N	S	N	S	S	S	S	S	Not required.
DUR/ PPS	N	S	S	S	S	S	S	S	Required **<12/04/2004>**.
Pricing	N	M	S	M	M	S	S	S	Required **<12/04/2004>**.
Coupon	N	S	N	S	S	S	S	S	No planned requirements at this time; **may be required at a future date.**
Compound	N	S	N	S	S	S	S	S	**Will be required 2/01/2005.**
PA	N	S	N	S	M	S	M	M	No planned requirements at this time; **may be required at a future date.**
Clinical	N	S	N	S	S	N	N	S	Required **<12/04/2004>**.

NCPDP Designations:
M = Mandatory
S = Situational
N = Not Sent.

NOTE: Some segments indicated as "Situational" by NCPDP, may be "Required" to support specific transactions for this program.

2.7 Required Data Elements

The First Health Services system has program-specific "mandatory/required", "situational" and "not sent" data elements for each transaction. The pharmacy provider's software vendor will need the Payer Specifications before setting up the plan in the pharmacy's computer system. This will allow the provider access to the required fields. Please note the following descriptions regarding data elements:

Code	Description
M	Designated as **MANDATORY** in accordance with the NCPDP Telecommunication Implementation Guide Version 5.1. These fields must be sent if the segment is required for the transaction.
S	Designated as situational in accordance with the NCPDP Telecommunication Implementation Guide Version 5.1. It is necessary to send these fields in noted situations. Some fields designated as situational by NCPDP may be required for all Kentucky Medicaid transactions.
R***	The "R***" indicates that the field is repeating. One of the other designators, "M", or "S" will precede it.

Kentucky Medicaid claims will not be processed without all the required data elements. Required fields may or may not be used in the adjudication process. The complete Kentucky Medicaid Payer Specifications, including NCPDP field number references, is in *Appendix B*. Fields "not required for this program" at this time may be required at a future date.

NOTE: The following list provides important identification numbers for this program:

• ANSI BIN #	Ø11529
• Processor Control #	PØ22Ø11529
• Group #	KYMEDICAID
• Provider ID #	Kentucky Medicaid **10-digit** Provider Number; includes 2 trailing zeros (e.g., 12345678 should be submitted as 1234567800)
• Cardholder ID #	Kentucky Medicaid Identification Number or Temporary ID
• Prescriber ID #	State License Number
• Product Code	National Drug Code (NDC)

2.8 Timely Filing Limits

Point of sale claims are generally submitted at the time of dispensing. However there may be mitigating reasons that require a claim to be submitted after being dispensed.

- For all original claims, reversals and adjustments, the timely filing limit from the date of service (DOS) is 366 days.
- Claims that exceed the prescribed timely filing limit will **deny** with NCPDP Error 81/ *Timely Filing Exceeded.* Requests for overrides to Timely Filing Limits should be directed to First Health Services.

Section 3: Program Particulars

3.1 Dispensing Limits

Days Supply

- Per Rx maximum = 32 days.
- Exceptions:

  - Maintenance Drugs:
    - The Department has identified a list of approved maintenance drugs. These drugs are identified in a list approved by the Department and posted on the website.
    - For those drugs, providers should dispense up to a 93-day supply or 100 units whichever is greater as per the prescriber's directions.

  - Intact Package Size Drugs:
    - The Department has identified a list of approved intact package size drugs. These drugs are identified in a list approved by the Department and posted on the website.
    - For those drugs providers should dispense the appropriate days supply and quantity as per the prescriber's directions not to exceed 93 days supply or 100 units whichever is greater.

Maximum Quantity

- Designated drugs are limited to quantity limits. These drugs are identified in a list approved by the Department and posted on the website.
- Quantity limits may be per fill or cumulative over a designated timeframe.
- Providers should submit a Prior Authorization request for override consideration.

Maximum Duration

- Designated drugs are limited to a maximum annual or lifetime duration of therapy. These drugs are identified in a list approved by the Department and posted on the website.
- Providers should submit a Prior Authorization request for override consideration.

Refills

- Non-controlled drugs: limited to an original plus up to 11 refills within 366 days from original Date Rx Written.
- Schedule II: no refills allowed.
- Schedule III - IV - V: limited to an original plus 5 refills within 180 days from original Date Rx Written.

Partial Fills

- In those cases where a provider does not dispense the full amount per the prescriber's directions, the pharmacy provider should submit the claim as a partial fill and indicate as such on the claim transaction.
- The dispense fees will be prorated based on the actual quantity dispensed as indicated on the incoming claim.
- The copayment, if applicable, will be prorated based on the actual quantity dispensed as indicated on the incoming claim.

Age

- Prenatal vitamins: limited to 50 years old and under.
- Multi-vitamins w/ fluoride: limited to 16 years old and under.

Gender

- Prenatal vitamins: limited to females.
- Viagra = limited to males.
- Levitra = limited to males.
- Cialis = limited to males.

Dollar Limit

- Claims with a dollar amount greater than $5,000 will deny and return NCPDP EC# 78/ *Cost Exceeds Maximum.*
    - Providers should validate that the appropriate quantity was entered.
    - Providers may contact the Technical Call Center for override consideration.

Diagnosis Code

- Providers should enter the appropriate ICD-9 code to indicate the patient's diagnosis.

3.2 Mandatory Generic Requirements

- Providers should dispense generic drugs whenever appropriate.
- Multi-source brand drugs without a SMAC will require prior authorization.

3.3 State Maximum Allowable Cost (SMAC) Program

The Maximum Allowable Cost (MAC) Program is a service developed and maintained by First Health Services Corporation (FHSC) for use by Kentucky Medicaid. Its purpose is to encourage a provider to use a cost effective therapeutically equivalent drug. FHSC's Clinical Management Consultants continually review the most current drug price sources. A generic drug may be considered for MAC pricing if there are 2 or more multi-source drugs with a significant cost difference. Other factors considered are rebate status, therapeutic equivalency ratings and availability in the marketplace. Multiple drug pricing resources are utilized to approximate, as closely as possible, the Estimated Acquisition Cost (EAC) for the lower priced generic drugs. The MAC pricing is updated on the 10th of each month. Other updates may occur between these dates if required by changes in the marketplace. The specific drug pricing resources and MAC prices are proprietary and confidential. Distribution and access to any MAC price information is for the sole purpose of assisting Kentucky Providers in submitting claims to Kentucky Medicaid and understanding Kentucky Medicaid's claims reimbursement. Any other use is prohibited.

The MAC list can be found in a query format at the website http://kentucky.fhsc.com. In this list, the provider can enter the first letter(s) of the generic name and will receive a list of all generic drugs beginning with the chosen letter(s). The provider can click on the desired generic name and receive the MAC price for that drug. If a provider prefers a hardcopy of MAC price list, a request form can be found on the http://Kentucky.fhsc.com website. The provider can print and complete the form. Upon signing the acceptance of the Confidentiality Terms, the provider can mail the completed form to FHSC and a copy of the MAC list will be mailed to the provider.

If a provider does not think a MAC price is valid, they may appeal the price by e-mailing or faxing a completed MAC List Price Research Request form to FHSC. The form can be found on the http://Kentucky.fhsc.com website. The provider can also appeal through the FHSC technical call center which will take the provider's information and drug NDC number in question. This information will be forwarded immediately to the plan administrator and/or MAC coordinator. They will investigate and resolve the appeal within 3 business days. If available, the provider will be supplied with 1 or more manufacturers that have a price comparable to the MAC price. If it is determined that there are no longer any manufacturers in that price range or if the provider can document that he/she does not have access to the supplied manufacturers, the MAC price and effective date will be adjusted accordingly, retroactive to the date of service for the MAC price prescription in question. Once the change is in effect, the provider will be informed that the claim can be rebilled for the price adjustment.

3.4 Drug Coverage

Included:

- All federal legend drugs are covered except:
  - A drug if used for anorexia, weight loss, or weight gain;
  - A drug if used to promote fertility;
  - A drug if used for cosmetic purposes or hair growth;
  - A drug if used for the symptomatic relief of cough and colds;
  - A drug if used to promote smoking cessation;
  - Vitamin or mineral products other than prenatal vitamins and fluoride preparations.

- All rebatable OTC drugs* are covered for ambulatory recipients except:
  - supplies;
  - herbals.

  * A prescription is required.

Excluded:

- DESI, IRS or LTE drugs;
- Diagnostics;
- Supplies;
- Non-rebatable products except for covered vitamins and vaccines.

Prior Authorization:

- Designated drugs require Prior Authorization. These drugs are identified in a list approved by the Department and posted on the website.
- Providers should submit a Prior Authorization request for override consideration.

Preferred Drug List (PDL):

- Designated drugs are considered non-preferred. These drugs are identified in a list approved by the Department and posted on the website.
- Providers should submit a Prior Authorization request for override consideration.

Step Therapy:

- Designated drugs require step therapy. These drugs are identified in a list approved by the Department and posted on the website.
- Providers should submit a Prior Authorization request for override consideration.

3.5 Recipient Payment Information

Copay

- The standard copay is $1.00.
  - Exceptions to copay:
    - If the recipient is pregnant or within 60 days post partum the provider should enter a PREGNANCY INDICATOR (NCPDP Field #335-2C) = "2" on the claim to waive copay.
    - The system will recognize family planning drugs (contraceptives) and will automatically waive copay.
    - Until the multi-ingredient compound functionality is implemented in February 2005, providers should enter PRIOR AUTHORIZATION TYPE (NCPDP Field # 461-EU) = "04" (waive copay) for any claims related to the compound except for the first claim.
    - If the recipient is in a Long Term Care facility, the provider should enter PATIENT LOCATION (NCPDP Field # 307-C7) = "3" (Nursing Home) to waive copay.
    - The system will recognize if the recipient is under age 18 and will automatically waive copay.

Annual Benefit Maximum

- There is no annual benefit maximum.

Deductible

- There is no deductible.

Out of Pocket

- There is no out of pocket.

Benefit Maximum

- There is no benefit maximum.

3.6 Prior Authorization

The First Health Services prior authorization (PA) process is designed to provide rapid, timely responses to prior authorization requests. Prior authorizations will be managed for Kentucky Medicaid by one of three methods:

1. First Health Services Clinical Call Center
2. First Health Services Technical Call Center
3. Direct pharmacy level overrides

The following tables provide the products for each prior authorization method.

3.6.1 Prior Authorization: Clinical Call Center

For prior authorization or override consideration regarding the following denial reasons:	Contact the First Health Services Clinical Call Center: 800-477-3071 Normal FAX: 800-365-8835 Urgent FAX: 800-421-9064 LTC FAX: 800-453-2273
Prior Authorization Required	Pharmacy provider or prescriber sends fax using appropriate form.
PDL	Pharmacy provider or prescriber sends fax using appropriate form.
H2RAs	Pharmacy provider or prescriber sends fax using appropriate form.
Quantity/ Days Supply/ Dosing Limitations	Pharmacy provider or prescriber sends fax using appropriate form.
Step Therapy	Pharmacy provider or prescriber sends fax using appropriate form.
Brand Necessary	Prescriber sends fax using appropriate form.
Medicare Part B	A claim for a Medicare covered drug will deny if the recipient enrollment information indicates that recipient is has Medicare Part B coverage for the DOS. If the drug is being administered for a non-Medicare covered reason the pharmacy provider or prescriber sends fax using appropriate form.
ProDUR • **Drug/ Drug** • **Therapeutic Duplication** atypical antipsychotics, narcotic analgesics and anti-anxiety drugs • **Early Refill for CIIs (and all controlled substances at a later date)**	Pharmacy provider or prescriber to call **800-477-3071.**

3.6.2 Prior Authorization/ Override: Technical Call Center

For override consideration regarding the following denial reasons:	Contact the First Health Services Technical Call Center: 800-432-7005
Dollar limit	A claim greater than $5,000 will deny. Providers should first validate that the appropriate quantity has been submitted. Providers should then contact First Health Services for override consideration.
Timely Filing Limits	A claim exceeding 366 days from the original DOS will deny. Providers should contact First Health Services for override consideration.

3.6.3 Provider level overrides

For override consideration regarding the following denial reasons:	Provider level overrides allowed
ProDUR	Providers may override the following ProDUR conditions: o Therapeutic Duplication (except for atypical antipsychotics, narcotic analgesics and anti-anxiety drugs); o Duplicate Ingredient; o Early Refill (except for Schedule II drugs. At a future date, providers will be required to obtain prior authorization for early refills on all controlled drugs.) ➢ In order to override when approved conditions are met, providers should use appropriate DUR codes to indicate the Reason for Service (Conflict), Professional Service (Intervention) and Result of Service (Outcome).
Emergency	Providers may override Prior Authorization conditions in emergency situations. ➢ In order to override when approved conditions are met, providers should enter the appropriate Level of Service code to override.
COB/ TPL	Providers may override coordination of benefits (COB) using designated override codes in approved conditions. ➢ In order to override when approved conditions are met, providers should enter the appropriate COB codes and/ or Prior Authorization Type code.
Copay on Compound	Providers should override a recipient's copay on all claims related to a compound except for the first claim. ➢ In order to override when approved conditions are met, providers should enter the appropriate Prior Authorization Type code.

3.7 Emergency Procedures

- Providers may override PA Requirements by entering LEVEL OF SERVICE (NCPDP Field #418-DI) = "3" (emergency) under the following guidelines:
  - Overrides must be outside of operational hours of the PA Call Center except for LTC facilities where the override may be outside of 5:00 p.m.
  - Overrides must be for a 3-day supply except where the package must be dispensed intact. Use the intact list if drug must be dispensed intact. See page 11.
  - OTCs cannot be overridden;
  - Drugs normally not covered cannot be overridden.

3.8 Coordination of Benefits (COB)

- On-line COB (cost avoidance) is required.
- Kentucky Medicaid is always the payer of last resort. Providers must bill all other payers first and then bill Kentucky Medicaid.
- First Health Services will return the following Other Payer details in the "Additional Message" field:
  - Other Payer ID
  - Other Payer (carrier) Name
  - Policy Number
- Reimbursement will be calculated to pay up to the Medicaid allowed amount less the third-party payment.
- Claims submitted with PRIOR AUTHORIZATION TYPE CODE (NCPDP Field #461-EU) = "8" (payer defined exemption) will bypass the TPL editing for all carriers and pay (pay and chase).
- Claims submitted for recipients under age 21 will automatically bypass the TPL editing and pay (pay and chase). For those recipients who are within the birth month of their 21st birthday, providers should enter PRIOR AUTHORIZATION TYPE CODE (NCPDP Field #461-EU) = "8" (payer defined exemption) to waive the TPL denial.

TPL PROCESSING GRID:

Other Coverage Code (NCPDP Field # 308-C8)	Claim Disposition	Notes
0 = Not specified		This code will not override TPL File.
1 = No other coverage identified	Allow for override.	Used when primary is billed and responds patient not on file. NCPDP Error Code #65 (see OCC 7)
2 = Other coverage exists, payment collected	Allow for override.	Used when payment is collected from the primary.
3 = Other coverage exists, claim not covered	Allow for override.	Used when the primary denies the claim for drug not covered. NCPDP Error Code #70, 73, 76
4 = Other coverage exists, payment not collected	Allow for override.	Used when the primary pays the claim but does not receive anything from the primary due to e.g., deductible.
5 = Managed care plan denial	Do not allow for override.	No industry protocols for standard usage.
6 = Other coverage exists, not a participating provider	Allow for override.	Used when the provider is not in the network for the primary. NCPDP Error Code #40
7 = Other coverage exists, not in effect on DOS	Allow for override.	Used when primary is billed and denies for e.g., patient coverage terminated. NCPDP Error Code #65, 67, 68, 69
8 = Copay only	Do not allow for override.	Intended for use in higher NCPDP versions.

OTHER PAYER REJECT CODE (NCPDP FIELD # 472-6E)

"40" - Pharmacy not contracted with plan on date of service.
"65" - Patient is not covered.
"67" - Filled before coverage effective.
"68" - Filled after coverage expired.
"69" - Filled after coverage terminated.
"70" - Product/Service not covered.
"73" - Refills are not covered.
"76" - Plan limitations exceeded.

3.9 Long Term Care (LTC)

- Providers should enter PATIENT LOCATION CODE (NCPDP Field # 307-C7) = "3" (Nursing Home) in order to identify that the patient is in a Long-Term-Care (LTC) facility.
- Providers should indicate pharmacy repackaging should by entering a UNIT DOSE INDICATOR (NCPDP Field # 429-DT) = "03". (Pharmacy Repackage) and the appropriate amount in the INCENTIVE AMOUNT SUBMITTED (NCPDP Field #438-E3).
- Additional information regarding LTC processing is available on the website.

3.10 Medicare Covered Drugs

- Drugs designated as Medicare-covered are not covered for recipients who have Medicare Part B coverage. These claims will deny with NCPDP Error Code 70 and the supplemental message *"Bill Medicare"*. Crossover billing is not part of the POS system. Providers should request override consideration to First Health Services' Clinical Call Center when the drug is being administered for a non-Medicare covered indication.

3.11 Compounds or Home IV

- Submit one claim for each NDC that is part of the compound.
- Recipient pays copay on first claim only. The provider must enter PRIOR AUTHORIZATION TYPE CODE (NCPDP Field # 461-EU) = "4" (exemption from copay) on subsequent claims (that is claims other than the first claim of the compound).
- Providers must enter a different Rx Number for each compound claim.
- Note that effective February 1, 2005 all providers who are submitting compounds must use the Compound Segment and submit as a single transaction.

3.12 Lock-In

- A recipient may be locked in to a prescriber, or pharmacy provider. Additionally, recipients may be locked in to both a prescriber and pharmacy provider.

Section 4: Prospective Drug Utilization Review (ProDUR)

Prospective Drug Utilization Review (ProDUR) encompasses the detection, evaluation, and counseling components of pre-dispensing drug therapy screening. The ProDUR system of First Health Services assists the pharmacist in these functions by addressing situations in which potential drug problems may exist. ProDUR performed prior to dispensing helps pharmacists ensure that their patients receive appropriate medications. This is accomplished by providing information to the dispensing pharmacist that may not have been previously available.

Because First Health Services' ProDUR system examines claims from all participating pharmacies, drugs that interact or are affected by previously dispensed medications can be detected. First Health Services recognizes that the pharmacist uses his/her education and professional judgment in all aspects of dispensing. ProDUR is offered as an informational tool to aid the pharmacist in performing his/her professional duties.

4.1 Therapeutic Problems

Prospective (concurrent) Drug Utilization Review edits apply to all claims unless otherwise identified.

4.2 Clinical Call Center

First Health Services Clinical Call Center is available 24 hours per day, seven days a week. The telephone number is 800-477-3071. Alert message information is available from the Call Center after the message appears. If you need assistance with any alert or denial messages, it is important to contact the Call Center about First Health Services ProDUR messages at the time of dispensing. The Call Center can provide claims information on all error messages, which are sent by the ProDUR system. This information includes: NDCs and drug names of the affected drugs, dates of service, whether the calling pharmacy is the dispensing pharmacy of the conflicting drug, and days supply.

The Call Center is not intended to be used as a clinical consulting service and cannot replace or supplement the professional judgment of the dispensing pharmacist. First Health Services has used reasonable care to accurately compile ProDUR information. Because each clinical situation is unique, this information is intended for pharmacists to use at their own discretion in the drug therapy management of their patients.

A second level of assistance is available if a provider's question requires a clinical response. To address these situations, First Health Services staff pharmacists are available for consultation.

First Health Services ProDUR is an integral part of the claims adjudication process. ProDUR includes: reviewing claims for therapeutic appropriateness before the medication is dispensed, reviewing the available medical history, focusing on those patients at the highest severity of risk for harmful outcome, and intervening and/or counseling when appropriate.

4.3 ProDUR Alert/Error Messages

All ProDUR alert messages appear at the end of the claims adjudication transmission. Alerts will appear in the following format:

FORMAT	FIELD DEFINITIONS
REASON FOR SERVICE:	2 characters. Code identifying the type of utilization conflict detected; e.g., "TD" (Therapeutic Duplication).
CLINICAL SIGNIFICANCE:	1 character. Code indicating the significance or severity level of a clinical event. 1 = Major 2 = Moderate 3 = Minor
OTHER PHARMACY INDICATOR:	1 character. Indicates if the dispensing provider also dispensed the first drug in question. 0 = No Value 1 = Your pharmacy 3 = Other pharmacy
PREVIOUS DATE OF FILL:	8 characters. Indicates previous fill date of conflicting drug in YYYYMMDD format.
QUANTITY OF PREVIOUS FILL:	5 characters. Indicates quantity of conflicting drug previously dispensed.
DATA BASE INDICATOR:	1 character. Indicates source of ProDUR message. 1 = First DataBank 4 = Processor Developed
OTHER PRESCRIBER:	1 character. Indicates the prescriber of conflicting prescription. 0 = No Value 1 = Same Prescriber 2 = Other Prescriber

Section 5: Edits

5.1 On Line Claims Processing Messages

Following an on-line claim submission by a pharmacy, the system will return a message to indicate the outcome of processing. If the claim passes all edits, a "**Paid**" message will be returned with Kentucky Medicaid's allowed amount for the paid claim. A claim that fails an edit and is rejected (denied) will also return a message. Following is a list of NCPDP rejects and descriptions.

As shown below, a NCPDP error code is returned with a NCPDP message. Where applicable, the NCPDP field that should be checked is referenced. Check the Solutions box if you are experiencing difficulties. For further assistance contact First Health Services at:

Technical Call Center
1-800-432-7005
(Nationwide Toll Free Number)

POINT OF SALE REJECT CODES AND MESSAGES
~ All edits may not apply to this program ~

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
	("M/I" Means Missing/Invalid)		
Ø1	M/I Bin	1Ø1	Enter Ø11529.
Ø2	M/I Version Number	1Ø2	NCPDP version 5.1 is required.
Ø3	M/I Transaction Code	1Ø3	Transactions allowed = B1, B2, B3.
Ø4	M/I Processor Control Number	1Ø4	Enter PØ22Ø11529.
Ø5	M/I Pharmacy Number	2Ø1	Enter Kentucky Medicaid Pharmacy Provider ID. Check with software vendor to ensure appropriate number has been set up in your system. Ensure that the 10-digit number ending in "00" is entered.
Ø6	M/I Group Number	3Ø1	Enter KYMEDICAID.

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
Ø7	M/I Cardholder ID Number	3Ø2	Enter Kentucky Medicaid Recipient ID number only; do not Enter any other patient ID. Do not enter any dashes. **Providers should always examine a Recipient 's ID card before services are rendered. It is the provider's responsibility to establish the identity of the recipient and to verify the effective date of coverage for the card presented.**
Ø8	M/I Person Code	3Ø3	
Ø9	M/I Birth Date	3Ø4	Format = YYYYMMDD (no dashes).
1C	M/I Smoker/Non-Smoker Code	334	
1E	M/I Prescriber Location Code	467	
1Ø	M/I Patient Gender Code	3Ø5	Values = 0/not specified; 1/male and 2/female.
11	M/I Patient Relationship Code	3Ø6	1 (cardholder).
12	M/I Patient Location	3Ø7	
13	M/I Other Coverage Code	3Ø8	See *Coordination of Benefits* section.
14	M/I Eligibility Clarification Code	3Ø9	
15	M/I Date of Service	4Ø1	Format = YYYYMMDD (no dashes). A future date is not allowed in this field.
16	M/I Prescription/Service Reference Number	4Ø2	Format = NNNNNNN.
17	M/I Fill Number	4Ø3	Enter "Ø" for a new prescription. Acceptable values for a refill prescription range from 1 to 99.
19	M/I Days Supply	4Ø5	Format = NNN. Enter the day's supply, "PRN" not allowed.
2C	M/I Pregnancy Indicator	335	Enter "2" to indicate the patient is pregnant or within 60 days post partum to waive copay.
2E	M/I Primary Care Provider ID Qualifier	468	
2Ø	M/I Compound Code	4Ø6	
21	M/I Product/Service ID	4Ø7	Enter 11-digit NDC only. Do not enter any dashes**.**
22	M/I Dispense As Written (DAW)/Product Selection Code	4Ø8	Enter "1" to indicate substitution not allowed by prescriber.
23	M/I Ingredient Cost Submitted	4Ø9	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
25	M/I Prescriber ID	411	Enter the State License Number for the state in which the prescriber practices. Do not Enter DEA Number or any other license number.
26	M/I Unit Of Measure	6ØØ	Enter the appropriate Unit of Measure for the product dispensed. Values = EA/ each, GM/ grams and ML/ milliliters.
28	M/I Date Prescription Written	414	Format = YYYYMMDD (no dashes). A future date is not allowed.
29	M/I Number Refills Authorized	415	Enter the number of refills as authorized by the prescriber.
3A	M/I Request Type	498-PA	
3B	M/I Request Period Date-Begin	498-PB	
3C	M/I Request Period Date-End	498-PC	
3D	M/I Basis Of Request	498-PD	
3E	M/I Authorized Representative First Name	498-PE	
3F	M/I Authorized Representative Last Name	498-PF	
3G	M/I Authorized Representative Street Address	498-PG	
3H	M/I Authorized Representative City Address	498-PH	
3J	M/I Authorized Representative State/Province Address	498-PJ	
3K	M/I Authorized Representative Zip/Postal Zone	498-PK	
3M	M/I Prescriber Phone Number	498-PM	
3N	M/I Prior Authorized Number Assigned	498-PY	
3P	M/I Authorization Number	5Ø3	
3R	Prior Authorization Not Required	4Ø7	
3S	M/I Prior Authorization Supporting Documentation	498-PP	
3T	Active Prior Authorization Exists Resubmit At Expiration Of Prior Authorization		
3W	Prior Authorization In Process		

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
3X	Authorization Number Not Found	5Ø3	
3Y	Prior Authorization Denied		
32	M/I Level Of Service	418	
33	M/I Prescription Origin Code	419	
34	M/I Submission Clarification Code	42Ø	
35	M/I Primary Care Provider ID	421	
38	M/I Basis Of Cost	423	
39	M/I Diagnosis Code	424	Enter the appropriate ICD-9 code.
4C	M/I Coordination Of Benefits/Other Payments Count	337	
4E	M/I Primary Care Provider Last Name	57Ø	
4Ø	Pharmacy Not Contracted With Plan On Date Of Service	None	Enter Kentucky Medicaid 10-digit Provider ID number only; check DOS. Call the Provider Enrollment Department if necessary.
41	Submit Bill To Other Processor Or Primary Payer	None	
5C	M/I Other Payer Coverage Type	338	
5E	M/I Other Payer Reject Count	471	
5Ø	Non-Matched Pharmacy Number	2Ø1	Enter Kentucky Medicaid Provider ID. Check lock-in status of recipient.
51	Non-Matched Group ID	3Ø1	Enter KYMEDICAID group only.
52	Non-Matched Cardholder ID	3Ø2	Enter Kentucky Medicaid ID number only; do not Enter any other patient ID. Do not enter any dashes.
53	Non-Matched Person Code	3Ø3	
54	Non-Matched Product/Service ID Number	4Ø7	Enter 11 digit NDC.
55	Non-Matched Product Package Size	4Ø7	
56	Non-Matched Prescriber ID	411	Enter State License Number.
58	Non-Matched Primary Prescriber	421	
6C	M/I Other Payer ID Qualifier	422	
6E	M/I Other Payer Reject Code	472	
6Ø	Product/Service Not Covered For Patient Age	3Ø2, 3Ø4, 4Ø1, 4Ø7	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
61	Product/Service Not Covered For Patient Gender	3Ø2, 3Ø5, 4Ø7	
62	Patient/Card Holder ID Name Mismatch	31Ø, 311, 312, 313, 32Ø	
63	Institutionalized Patient Product/Service ID Not Covered		Drug not covered for recipient in Long Term Care facility.
64	Claim Submitted Does Not Match Prior Authorization	2Ø1, 4Ø1, 4Ø4, 4Ø7, 416	
65	Patient Is Not Covered	3Ø3, 3Ø6	
66	Patient Age Exceeds Maximum Age	3Ø3, 3Ø4, 3Ø6	
67	Filled Before Coverage Effective	4Ø1	Enter Kentucky Medicaid ID number only; do not Enter any other patient ID. Do not enter any dashes. Check DOS. Check Group Number.
68	Filled After Coverage Expired	4Ø1	Enter Kentucky Medicaid ID number only; do not Enter any other patient ID. Do not enter any dashes. Check DOS. Check Group Number.
69	Filled After Coverage Terminated	4Ø1	
7C	M/I Other Payer ID	34Ø	
7E	M/I DUR/PPS Code Counter	473	
7Ø	Product/Service Not Covered	4Ø7	Enter 11-digit NDC. Drug not covered.
71	Prescriber Is Not Covered	411	
72	Primary Prescriber Is Not Covered	421	
73	Refills Are Not Covered	4Ø2, 4Ø3	
74	Other Carrier Payment Meets Or Exceeds Payable	4Ø9, 41Ø, 442	
75	Prior Authorization Required	462	Validate 11-digit NDC. Follow Prior Authorization procedures if appropriate.
76	Plan Limitations Exceeded	4Ø5, 442	Validate day's supply and quantity dispensed. Follow Prior Authorization procedures if appropriate.
77	Discontinued Product/Service ID Number	4Ø7	Validate 11-digit NDC. NDC is obsolete.
78	Cost Exceeds Maximum	4Ø7, 4Ø9, 41Ø, 442	Claims will deny if greater than $5000. Provider must contact FHSC for override consideration.

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
79	Refill Too Soon	4Ø1, 4Ø3, 4Ø5	80% day's supply of previous claim has not been utilized. Prior fill may be from a different provider.
8C	M/I Facility ID	336	
8E	M/I DUR/PPS Level Of Effort	474	
8Ø	Drug-Diagnosis Mismatch	4Ø7, 424	
81	Claim Too Old	4Ø1	Check DOS. Contact FHS for override consideration when appropriate.
82	Claim Is Post-Dated	4Ø1	
83	Duplicate Paid/Captured Claim	2Ø1, 4Ø1, 4Ø2, 4Ø3, 4Ø7	
84	Claim Has Not Been Paid/Captured	2Ø1, 4Ø1, 4Ø2	
85	Claim Not Processed	None	
86	Submit Manual Reversal	None	
87	Reversal Not Processed	None	Provider number, DOS and Rx number must equal original claim.
88	DUR Reject Error		
89	Rejected Claim Fees Paid		
9Ø	Host Hung Up		Processing Host Did Not Accept Transaction/Did Not Respond Within Time Out Period.
91	Host Response Error		
92	System Unavailable/Host Unavailable		
95	Time Out		
96	Scheduled Downtime		
97	Payer Unavailable		
98	Connection To Payer Is Down		
99	Host Processing Error		Do Not Retransmit Claim(s).
AA	Patient Spenddown Not Met		
AB	Date Written Is After Date Filled		
AC	Product Not Covered Non-Participating Manufacturer		
AD	Billing Provider Not Eligible To Bill This Claim Type		

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
AE	QMB (Qualified Medicare Beneficiary)-Bill Medicare		
AF	Patient Enrolled Under Managed Care		
AG	Days Supply Limitation For Product/Service		
AH	Unit Dose Packaging Only Payable For Nursing Home Recipients		
AJ	Generic Drug Required		
AK	M/I Software Vendor/Certification ID	11Ø	
AM	M/I Segment Identification	111	
A9	M/I Transaction Count	1Ø9	
BE	M/I Professional Service Fee Submitted	477	
B2	M/I Service Provider ID Qualifier	2Ø2	Enter “Ø5” Medicaid ID.
CA	M/I Patient First Name	31Ø	
CB	M/I Patient Last Name	311	
CC	M/I Cardholder First Name	312	
CD	M/I Cardholder Last Name	313	
CE	M/I Home Plan	314	
CF	M/I Employer Name	315	
CG	M/I Employer Street Address	316	
CH	M/I Employer City Address	317	
CI	M/I Employer State/Province Address	318	
CJ	M/I Employer Zip Postal Zone	319	
CK	M/I Employer Phone Number	32Ø	
CL	M/I Employer Contact Name	321	
CM	M/I Patient Street Address	322	
CN	M/I Patient City Address	323	
CO	M/I Patient State/Province Address	324	
CP	M/I Patient Zip/Postal Zone	325	
CQ	M/I Patient Phone Number	326	
CR	M/I Carrier ID	327	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
CW	M/I Alternate ID	33Ø	
CX	M/I Patient ID Qualifier	331	
CY	M/I Patient ID	332	
CZ	M/I Employer ID	333	
DC	M/I Dispensing Fee Submitted	412	
DN	M/I Basis Of Cost Determination	423	
DQ	M/I Usual And Customary Charge	426	
DR	M/I Prescriber Last Name	427	
DT	M/I Unit Dose Indicator	429	
DU	M/I Gross Amount Due	43Ø	
DV	M/I Other Payer Amount Paid	431	
DX	M/I Patient Paid Amount Submitted	433	Do not submit any value > Ø.
DY	M/I Date Of Injury	434	
DZ	M/I Claim/Reference ID	435	
EA	M/I Originally Prescribed Product/Service Code	445	
EB	M/I Originally Prescribed Quantity	446	
EC	M/I Compound Ingredient Component Count	447	
ED	M/I Compound Ingredient Quantity	448	
EE	M/I Compound Ingredient Drug Cost	449	
EF	M/I Compound Dosage Form Description Code	45Ø	
EG	M/I Compound Dispensing Unit Form Indicator	451	
EH	M/I Compound Route Of Administration	452	
EJ	M/I Originally Prescribed Product/Service ID Qualifier	453	
EK	M/I Scheduled Prescription ID Number	454	
EM	M/I Prescription/Service Reference Number Qualifier	445	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
EN	M/I Associated Prescription/Service Reference Number	456	
EP	M/I Associated Prescription/Service Date	457	
ER	M/I Procedure Modifier Code	459	
ET	M/I Quantity Prescribed	46Ø	
EU	M/I Prior Authorization Type Code	461	
EV	M/I Prior Authorization Number Submitted	462	
EW	M/I Intermediary Authorization Type ID	463	
EX	M/I Intermediary Authorization ID	464	
EY	M/I Provider ID Qualifier	465	
EZ	M/I Prescriber ID Qualifier	466	Enter “08” State License Number.
E1	M/I Product/Service ID Qualifier	436	
E3	M/I Incentive Amount Submitted	438	
E4	M/I Reason For Service Code	439	
E5	M/I Professional Service Code	44Ø	
E6	M/I Result Of Service Code	441	
E7	M/I Quantity Dispensed	442	
E8	M/I Other Payer Date	443	
E9	M/I Provider ID	444	
FO	M/I Plan ID	524	
GE	M/I Percentage Sales Tax Amount Submitted	482	
HA	M/I Flat Sales Tax Amount Submitted	481	
HB	M/I Other Payer Amount Paid Count	341	
HC	M/I Other Payer Amount Paid Qualifier	342	
HD	M/I Dispensing Status	343	
HE	M/I Percentage Sales Tax Rate Submitted	483	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
HF	M/I Quantity Intended To Be Dispensed	344	
HG	M/I Days Supply Intended To Be Dispensed	345	
H1	M/I Measurement Time	495	
H2	M/I Measurement Dimension	496	
H3	M/I Measurement Unit	497	
H4	M/I Measurement Value	499	
H5	M/I Primary Care Provider Location Code	469	
H6	M/I DUR Co-Agent ID	476	
H7	M/I Other Amount Claimed Submitted Count	478	
H8	M/I Other Amount Claimed Submitted Qualifier	479	
H9	M/I Other Amount Claimed Submitted	48Ø	
JE	M/I Percentage Sales Tax Basis Submitted	484	
J9	M/I DUR Co-Agent ID Qualifier	475	
KE	M/I Coupon Type	485	
M1	Patient Not Covered In This Aid Category		
M2	Recipient Locked In		
M3	Host PA/MC Error		
M4	Prescription/Service Reference Number/Time Limit Exceeded		
M5	Requires Manual Claim		
M6	Host Eligibility Error		
M7	Host Drug File Error		
M8	Host Provider File Error		
ME	M/I Coupon Number	486	
MZ	Error Overflow		
NE	M/I Coupon Value Amount	487	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
NN	Transaction Rejected At Switch Or Intermediary		
PA	PA Exhausted/Not Renewable		
PB	Invalid Transaction Count For This Transaction Code	1Ø3, 1Ø9	
PC	M/I Claim Segment	111	
PD	M/I Clinical Segment	111	
PE	M/I COB/Other Payments Segment	111	
PF	M/I Compound Segment	111	
PG	M/I Coupon Segment	111	
PH	M/I DUR/PPS Segment	111	
PJ	M/I Insurance Segment	111	
PK	M/I Patient Segment	111	
PM	M/I Pharmacy Provider Segment	111	
PN	M/I Prescriber Segment	111	
PP	M/I Pricing Segment	111	
PR	M/I Prior Authorization Segment	111	
PS	M/I Transaction Header Segment	111	
PT	M/I Workers' Compensation Segment	111	
PV	Non-Matched Associated Prescription/Service Date	457	
PW	Non-Matched Employer ID	333	
PX	Non-Matched Other Payer ID	34Ø	
PY	Non-Matched Unit Form/Route of Administration	451, 452, 6ØØ	
PZ	Non-Matched Unit Of Measure To Product/Service ID	4Ø7, 6ØØ	
P1	Associated Prescription/Service Reference Number Not Found	456	
P2	Clinical Information Counter Out Of Sequence	493	
P3	Compound Ingredient Component Count Does Not Match Number Of Repetitions	447	

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
P4	Coordination Of Benefits/Other Payments Count Does Not Match Number Of Repetitions	337	
P5	Coupon Expired	486	
P6	Date Of Service Prior To Date Of Birth	3Ø4, 4Ø1	
P7	Diagnosis Code Count Does Not Match Number Of Repetitions	491	
P8	DUR/PPS Code Counter Out Of Sequence	473	
P9	Field Is Non-Repeatable		
RA	PA Reversal Out Of Order		
RB	Multiple Partials Not Allowed		
RC	Different Drug Entity Between Partial & Completion		
RD	Mismatched Cardholder/Group ID-Partial To Completion	3Ø1, 3Ø2	
RE	M/I Compound Product ID Qualifier	488	
RF	Improper Order Of “Dispensing Status” Code On Partial Fill Transaction		
RG	M/I Associated Prescription/service Reference Number On Completion Transaction	456	
RH	M/I Associated Prescription/Service Date On Completion Transaction	457	
RJ	Associated Partial Fill Transaction Not On File		
RK	Partial Fill Transaction Not Supported		
RM	Completion Transaction Not Permitted With Same “Date Of Service” As Partial Transaction	4Ø1	
RN	Plan Limits Exceeded On Intended Partial Fill Values	344, 345	
RP	Out Of Sequence “P” Reversal On Partial Fill Transaction		

Reject Code	Explanation	Field Number Possibly In Error	Possible Solutions
RS	M/I Associated Prescription/Service Date On Partial Transaction	457	
RT	M/I Associated Prescription/Service Reference Number On Partial Transaction	456	
RU	Mandatory Data Elements Must Occur Before Optional Data Elements In A Segment		
R1	Other Amount Claimed Submitted Count Does Not Match Number Of Repetitions	478, 48Ø	
R2	Other Payer Reject Count Does Not Match Number Of Repetitions	471, 472	
R3	Procedure Modifier Code Count Does Not Match Number Of Repetitions	458, 459	
R4	Procedure Modifier Code Invalid For Product/Service ID	4Ø7, 436, 459	
R5	Product/Service ID Must Be Zero When Product/Service ID Qualifier Equals Ø6	4Ø7, 436	
R6	Product/Service Not Appropriate For This Location	3Ø7, 4Ø7, 436	
R7	Repeating Segment Not Allowed In Same Transaction		
R8	Syntax Error		
R9	Value In Gross Amount Due Does Not Follow Pricing Formula	43Ø	
SE	M/I Procedure Modifier Code Count	458	
TE	M/I Compound Product ID	489	
UE	M/I Compound Ingredient Basis Of Cost Determination	49Ø	
VE	M/I Diagnosis Code Count	491	
WE	M/I Diagnosis Code Qualifier	492	
XE	M/I Clinical Information Counter	493	
ZE	M/I Measurement Date	494	

5.2 Host System Problems

Occasionally providers may receive a message that indicates their network is having technical problems communicating with First Health Services.

NCPDP	Message
90	Host Hung Up

Host disconnected before session completed.

NCPDP	Message
92	System Unavailable/Host Unavailable

Processing host did not accept transaction or did not respond within time out period.

NCPDP	Message
93	Planned Unavailable

Transmission occurred during scheduled downtime. First Health Services will provide system availability:

SYSTEM HOURS OF AVAILABILITY:
24 hours availability
Except Saturday into Sunday

- Saturday down at 11:00 p.m., ET
- Sunday up at 6:00 a.m., ET

NCPDP	Message
99	Host Processing Error

Do not retransmit claims.

5.3 DUR Fields

In those cases where provider-level overrides have been authorized, providers should use the following codes when applicable.

NCPDP	*Message*
88	DUR Reject Error

DUR Reason for Service:
The DUR Reason for Service (previously "Conflict Code") is used to define the type of utilization conflict that was detected (NCPDP Field #439-E4).

Valid DUR Reason for Service Codes for the Kentucky Medicaid program are:

- **ER** NON-CONTROLLED EARLY REFILL 80%
- **DD** DRUG/ DRUG
- **TD** THERAPEUTIC DUPLICATION
- **ID** DUPLICATE INGREDIENT

NCPDP	*Message*
E4	M/I DUR conflict/reason for service code

DUR Professional Service:
The DUR Professional Service (previously "Intervention Code") is used to define the type of interaction or intervention that was performed by the pharmacist (NCPDP Field #440-E5).

Valid DUR Professional Service Codes for the Kentucky Medicaid program are:

- **GP** GENERIC PRODUCT SELECTION
- **MØ** PRESCRIBER CONSULTED
- **MR** MEDICATION REVIEW
- **PH** PATIENT MEDICATION HISTORY
- **PØ** PATIENT CONSULTED
- **RØ** RPH CONSULTED OTHER SOURCE

NCPDP	*Message*
E5	M/I DUR intervention/professional service code

DUR Result of Service:

The DUR Result of Service (previously "Outcome Code") is used to define the action taken by the pharmacist in response to a ProDUR Reason for Service or the result of a pharmacist's professional service (NCPDP Field #441-E6).

Valid DUR Result of Services codes for the Kentucky Medicaid are:

- **1A** FILLED AS IS, FALSE POSITIVE
- **1B** FILLED PRESCRIPTION AS IS
- **1C** FILLED WITH DIFFERENT DOSE
- **1D** FILLED WITH DIFFERENT DIRECTIONS
- **1E** FILLED WITH DIFFERENT DRUG
- **1F** FILLED WITH DIFFERENT QUANTITY
- **1G** FILLED WITH PRESCRIBER APPROVAL
- **2A** PRESCRIPTION NOT FILLED
- **2B** NOT FILLED, DIRECTIONS CLARIFIED
- **3C** DISCONTINUED
- **3D** REGIMEN CHANGED
- **3E** THERAPY CHANGED

NCPDP	*Message*
E6	M/I DUR outcome/result of service code

Section 6: Provider Reimbursement

6.1 Provider Payment Algorithms

- The provider is paid at the lesser of:
  - AWP - 12% + $4.51, or
  - FUL + $4.51, or
  - MAC + $4.51, or
  - Usual and Customary
  - Gross Amount Due (effective January 4, 2005)

Special pricing:

Brand PA (with approved brand PA):

- Pays lesser of:
  - AWP - 12% + $4.51
  - Usual and Customary
  - Gross Amount Due (effective January 4, 2005)

340b:

- Providers should submit acquisition costs as U/C. Standard Payment Algorithm used.

Unit dose repackaging:

- Providers will be reimbursed $.02 cents per unit for repackaging products into unit-dose packaging. Providers are eligible for this fee for solid-dosage forms only for those products not packaged as unit-dose by the manufacturer. The cap is $2.00 per Rx.

6.2 Provider Dispensing Fees

- Standard = $4.51
- LTC = $4.51
- Compound = $4.51

APPENDIX A: Universal Claim Form

Universal Claim Form

The **Universal Claim Form (UCF)** will be required for all paper claims. UCFs can be obtained from your wholesaler and should be submitted to First Health Services. (See Section 1.2 Addresses for Paper Claims mailing address.)

How to Complete 5.1 UCF Form

1. Fill in all applicable areas on the front of the form.
2. Verify patient information is correct and that patient named is eligible for benefits.
3. Patient signs certification on front side for prescription(s) received.
4. Enter Compound Rx in the Product Service ID area and list each ingredient name, NDC, quantity, and cost in the area below. Please use a separate claim form for each compound prescription.
5. Report diagnosis code and qualifier related to prescription (limit 1 per prescription).
6. Limit 1 set of DUR/PPS codes per claim.
7. Each area is numbered. Fill each area using the following codes:

DEFINITIONS/VALUES

1. OTHER COVERAGE CODE

1 = No other coverage identified
2 = Other coverage exists payment collected
3 = Other coverage exists this claim not covered
4 = Other coverage exists payment not collected
6 = Other coverage denied not a participating provider
7 = Other coverage exists not in effect at time of service

2. PERSON CODE

Code assigned to a specific person within a family. All recipient s are “01”.

3. PATIENT GENDER CODE

0 = Not specified
1 = Male
2 = Female

4. PATIENT RELATIONSHIP CODE
1 = Cardholder

5. SERVICE PROVIDER ID QUALIFIER
05 = Medicaid ID
99 = Other

6. CARRIER ID
Carrier code is assigned in the Worker's Compensation Program.

7. CLAIM/REFERENCE ID
Identifies the claim number assigned by Worker's Compensation Program.

8. PRESCRIPTION SERVICE REFERENCE # QUALIFIER
Blank = Not specified
1 = Rx billing
2 = Service bill

9. QUANTITY DISPENSED
Quantity dispensed expressed in metric decimal units (shaded areas for decimal values).

10. PRODUCT SERVICE ID QUALIFIER
Code qualifying the value in Product/Service ID (407-07).
03 = National Drug Code (NDC)

11. PRIOR AUTHORZATION TYPE CODE

0=Not specified	1=Prior Authorization	2=Medical Certification
3=EPSDT (Early Periodic Screening Diagnosis Treatment)	4=Exemption from copay	
6=Family Planning Indicator		8=Payer defined exemption

12. PRESCRIBER ID QUALIFIER
08 = State License Number

13. DUR/PROFESSIONAL SERVICE CODES
For values refer to current NCPDP data dictionary.
A = Reason for service
B = Professional Service code
C = Result of Service

14. BASIS OF COST DETERMINATION
01 = AWP (average wholesale price)
07 = Usual and Customary
09 = Other

15. PROVIDER ID QUALIFIER
05 = Medicaid ID

16. DIAGNOSIS CODE QUALIFER
00 = Not specified
Blank Not specified
01 = International Classification of Diseases (ICD9)
99 = Other

17. OTHER PAYER ID QUALIFIER
99 = Other

NOTE: Compound prescriptions - limit 1 compound prescription per claim form.

I.D. _____ GROUP I.D. _____

NAME _____ PLAN NAME _____

PATIENT NAME: _____ OTHER COVERAGE CODE (1) _____ PERSON CODE (2) _____

PATIENT DATE OF BIRTH ____ ____ _____ (MM DD CCYY) PATIENT (3) GENDER CODE _____ PATIENT (4) RELATIONSHIP CODE _____

PHARMACY NAME _____

ADDRESS _____ SERVICE PROVIDER I.D. _____ QUAL (5) _____ FOR OFFICE USE ONLY

CITY _____ PHONE NO. ( ) _____

STATE & ZIP CODE _____ FAX NO. ( ) _____

WORKERS COMP. INFORMATION
EMPLOYER NAME _____
ADDRESS _____
CITY _____ **STATE** _____ **ZIP CODE** _____
CARRIER I.D. (6) _____ **EMPLOYER PHONE NO.** _____
DATE OF INJURY ____ ____ _____ (MM DD CCYY) **CLAIM (7) REFERENCE I.D.** _____

I have hereby read the Certification Statement on the reverse side. I hereby certify to and accept the terms thereof. I also certify that I have received 1 or 2 (please circle number) prescription(s) listed below.

PATIENT/ AUTHORIZED REPRESENTATIVE _____

ATTENTION RECIPIENT PLEASE READ CERTIFICATION STATEMENT ON REVERSE SIDE

1 **1**

PRESCRIPTION / SERV. REF. #	QUAL (8)	DATE WRITTEN MM DD CCYY	DATE OF SERVICE MM DD CCYY	FILL #	QTY DISPENSED (9)	DAYS SUPPLY

PRODUCT / SERVICE I.D.	QUAL (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PRESCRIBER I.D.	QUAL (12)

DUR/PPS CODES (13)	BASIS COST (14)	PROVIDER I.D.	QUAL (15)	DIAGNOSIS CODE	QUAL (16)

OTHER PAYER DATE MM DD CCYY	OTHER PAYER I.D.	QUAL (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE

	INGREDIENT COST SUBMITTED
	DISPENSING FEE SUBMITTED
	INCENTIVE AMOUNT SUBMITTED
	OTHER AMOUNT SUBMITTED
	SALES TAX SUBMITTED
	GROSS AMOUNT DUE SUBMITTED
	PATIENT PAID AMOUNT
	OTHER PAYER AMOUNT PAID
	NET AMOUNT DUE

2 **2**

PRESCRIPTION / SERV. REF. #	QUAL (8)	DATE WRITTEN MM DD CCYY	DATE OF SERVICE MM DD CCYY	FILL #	QTY DISPENSED (9)	DAYS SUPPLY

PRODUCT / SERVICE I.D.	QUAL (10)	DAW CODE	PRIOR AUTH # SUBMITTED	PA TYPE (11)	PRESCRIBER I.D.	QUAL (12)

DUR/PPS CODES (13)	BASIS COST (14)	PROVIDER I.D.	QUAL (15)	DIAGNOSIS CODE	QUAL (16)

OTHER PAYER DATE MM DD CCYY	OTHER PAYER I.D.	QUAL (17)	OTHER PAYER REJECT CODES	USUAL & CUST. CHARGE

	INGREDIENT COST SUBMITTED
	DISPENSING FEE SUBMITTED
	INCENTIVE AMOUNT SUBMITTED
	OTHER AMOUNT SUBMITTED
	SALES TAX SUBMITTED
	GROSS AMOUNT DUE SUBMITTED
	PATIENT PAID AMOUNT
	OTHER PAYER AMOUNT PAID
	NET AMOUNT DUE

APPENDIX B: Payer Specification

➢ General Information:

PAYER: **KENTUCKY MEDICAID**	
Processor: **First Health Services**	Information Source: **First Health Services**
Effective as of: **December 4, 2004**	Document Date: **October 15, 2004**
Provider Help Desk Number: **800-432-7005**	Certification Help Number: **804 - 217 - 5060**
Other versions supported: **No**	

NCPDP Lower Version Transaction Code	***NCPDP* Lower Version Transaction Name**	**NCPDP Version 5.1 Transaction Code**	**NCPDP Version 5.1 Transaction Name**	**Transaction Support Requirements**
00	Eligibility Verification	E1	Eligibility Verification	Supported <**12/04/2004**>.
01 – 04	Rx Billing	B1	Billing	Required <**12/04/2004**>.
11	Rx Reversal	B2	Reversal	Required <**12/04/2004**>.
21 – 24	Rx Downtime Billing	N/A	N/A	Not supported in v.5.1.
31 – 34	Rx Re-billing	B3	Re-bill	Required <**12/04/2004**>.
41	Prior Authorization Request with Request for Payment	P1	Prior Authorization Request and Billing	Not required.
45	Prior Authorization Inquiry	P3	Prior Authorization Inquiry	Not required.
46	Prior Authorization Reversal	P2	Prior Authorization Reversal	Not required.
51	Prior Authorization Request Only	P4	Prior Authorization Request Only	Not required.

NCPDP Request Segment Matrix									**Segment Support Requirements**
Transaction Code	**E1**	**B1**	**B2**	**B3**	**P1**	**P2**	**P3**	**P4**	Some segments may be required at a future date to be determined.
Segment									
Header	M	M	M	M	M	M	M	M	Required <**12/04/2004**>.
Patient	S	S	S	S	S	S	S	S	Required <**12/04/2004**>.
Insurance	M	M	S	M	M	S	M	M	Required <**12/04/2004**>.
Claim	N	M	M	M	M	M	M	M	Required <**12/04/2004**>.
Pharmacy Provider	S	S	N	S	S	S	S	S	No planned requirements at this time; **may be required at a future date.**
Prescriber	N	S	N	S	S	S	S	S	Required <**12/04/2004**>.
COB/ Other Payments	N	S	N	S	S	N	S	S	Required <**12/04/2004**>.
Worker's Comp	N	S	N	S	S	S	S	S	Not required.
DUR/ PPS	N	S	S	S	S	S	S	S	Required <**12/04/2004**>.
Pricing	N	M	S	M	M	S	S	S	Required <**12/04/2004**>.
Coupon	N	S	N	S	S	S	S	S	No planned requirements at this time; **may be required at a future date.**
Compound	N	S	N	S	S	S	S	S	**Will be required February 1, 2005.**
PA	N	S	N	S	M	S	M	M	No planned requirements at this time; **may be required at a future date.**
Clinical	N	S	N	S	S	N	N	S	Required <**12/04/2004**>.

Program Highlights
The software/certification ID will control whether 5.1 claims will be accepted by the production system. Your software vendor will receive a number upon certification with First Health Services. This number must be included on the transaction header segment. Software vendors must be certified. Contact Vendor_Certification@fhsc.com or 804-217-5060.
Compounds will be processed on-line using the Compound Segment effective 02/01/2005. Providers should use existing protocols prior to that time.
Coordination of Benefits will be supported via the COB segment only.
In cases where multiple iterations of a field ("repeating fields") are allowed, the maximum number of iterations has been indicated.
Partial fills will be supported.
Reversals will match on Provider Number, RX Number, DOS and Product (NDC).
Any/ all submitted data elements will be edited for valid format and values.
Provider software should support any/ all data elements on the required segments.

Code	**Description**
M	Designated as **MANDATORY** in accordance with the NCPDP Telecommunication Implementation Guide Version 5.1. These fields must be sent if the segment is required for the transaction.
S	Designated as **SITUATIONAL** in accordance with the NCPDP Telecommunication Implementation Guide Version 5.1. It is necessary to send these fields in noted situations. Some fields designated as situational by NCPDP may be *required for all* KENTUCKY MEDICAID transactions. Some fields designated as situational by NCPDP may be *required for KENTUCKY MEDICAID transactions where specific conditions are met*.
X***R***	The "R***" indicates that the field is repeating.
NOTES: 1. Specific field values that are required for the program are identified as "**KENTUCKY MEDICAID VALUES SUPPORTED".**	

2. There will be additional information regarding field values in the Provider Manual.
3. Situational fields not required for this program at this time may be required in the future.
4. All **mandatory** fields are required. All bolded **situational** fields are required as indicated.

TRANSACTION HEADER SEGMENT		***Segment MANDATORY for all transactions.***	
Field	**Field Name**	**Mandatory Situational**	**KENTUCKY MEDICAID VALUES SUPPORTED**
1Ø1-A1	**BIN NUMBER**	**M**	**011529**
1Ø2-A2	**VERSION/RELEASE NUMBER**	**M**	**51**
1Ø3-A3	**TRANSACTION CODE**	**M**	**B1, B2, B3**
1Ø4-A4	**PROCESSOR CONTROL NUMBER**	**M**	**P022011529**
1Ø9-A9	**TRANSACTION COUNT**	**M**	**B1 = 1-4 (except multi-ingredient compound <when implemented> = 1) B2 = 1-4 (except multi-ingredient compound <when implemented> = 1) B3 = 1-4 (except multi-ingredient compound <when implemented> = 1)**
2Ø2-B2	**SERVICE PROVIDER ID QUALIFIER**	**M**	**Ø5 = Medicaid ID**
2Ø1-B1	**SERVICE PROVIDER ID**	**M**	**KY Medicaid ID (10-digit number ending in "ØØ")**
4Ø1-D1	**DATE OF SERVICE**	**M**	**Format = CCYYMMDD**
11Ø-AK	**SOFTWARE VENDOR/CERTIFICATION ID**	**M**	**Assigned when vendor is certified with First Health Services; will reject if missing or not valid.**

PATIENT SEGMENT		***Segment REQUIRED for these transactions: B1 and B3.***	
Field	**Field Name**	**Mandatory Situational**	**KENTUCKY MEDICAID VALUES SUPPORTED**
111-AM	**SEGMENT IDENTIFICATION**	**M**	**Ø1 = Patient Segment**
331-CX	PATIENT ID QUALIFIER	S	
332-CY	PATIENT ID	S	
3Ø4-C4	DATE OF BIRTH	S	
3Ø5-C5	PATIENT GENDER CODE	R	
31Ø-CA	PATIENT FIRST NAME	R	
311-CB	PATIENT LAST NAME	R	
322-CM	PATIENT STREET ADDRESS	S	
323-CN	PATIENT CITY ADDRESS	S	
324-CO	PATIENT STATE / PROVINCE ADDRESS	S	
325-CP	PATIENT ZIP/POSTAL ZONE	S	
326-CQ	PATIENT PHONE NUMBER	S	
3Ø7-C7	PATIENT LOCATION	S	
333-CZ	EMPLOYER ID	N	
334-1C	SMOKER / NON-SMOKER CODE	N	
335-2C	PREGNANCY INDICATOR	**RW**	Required when the patient is pregnant to waive copay.

INSURANCE SEGMENT		*Segment MANDATORY for these transactions: E1, B1, and B3.*	
Field	**Field Name**	**Mandatory Situational**	**KENTUCKY MEDICAID VALUES SUPPORTED**
111-AM	**SEGMENT IDENTIFICATION**	**M**	**Ø4 = Insurance Segment**
3Ø2-C2	**CARDHOLDER ID**	**M**	**Kentucky Medicaid ID Number <patient specific>**
312-CC	CARDHOLDER FIRST NAME	S	
313-CD	CARDHOLDER LAST NAME	S	
314-CE	HOME PLAN	S	
524-FO	PLAN ID	S	
3Ø9-C9	ELIGIBILITY CLARIFICATION CODE	S	
336-8C	FACILITY ID	S	
3Ø1-C1	**GROUP ID**	**R**	**Required for this program: KYMEDICAID**
3Ø3-C3	PERSON CODE	S	
3Ø6-C6	PATIENT RELATIONSHIP CODE	S	

CLAIM SEGMENT		*Segment MANDATORY for these transactions: B1, B2, and B3.*	
Field	**Field Name**	**Mandatory Situational**	**KENTUCKY MEDICAID VALUES SUPPORTED**
111-AM	**SEGMENT IDENTIFICATION**	**M**	**Ø7 = Claim Segment**
455-EM	**PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER**	**M**	**1 = Rx billing**
4Ø2-D2	**PRESCRIPTION/SERVICE REFERENCE NUMBER**	**M**	
436-E1	**PRODUCT/SERVICE ID QUALIFIER**	**M**	**Ø3 = NDC**
4Ø7-D7	**PRODUCT/SERVICE ID**	**M**	**NDC**
456-EN	**ASSOCIATED PRESCRIPTION/SERVICE REFERENCE #**	**RW**	**Required when the "completion" transaction in a partial fill (Dispensing Status (343-HD) = "C" (Completed)) and the Prescription/Service Reference Number (4Ø2-D2) changed from the "P" (Partial Fill).** **Required when the "P" (Partial Fill) is not the original fill and the Prescription/Service Reference Number (4Ø2-D2) has not changed.**
457-EP	**ASSOCIATED PRESCRIPTION/SERVICE DATE**	**RW**	**Required when the "completion" transaction in a partial fill (Dispensing Status (343-HD) = "C" (Completed)).** **Required when Associated Prescription/Service Reference Number (456-EN) is used.** **Required when the "P" (Partial Fill) transaction is not the original fill.**
458-SE	PROCEDURE MODIFIER CODE COUNT	S	
459-ER	PROCEDURE MODIFIER CODE	S***R***	
442-E7	**QUANTITY DISPENSED**	**R**	**Required for this program.**
4Ø3-D3	**FILL NUMBER**	**R**	**Required for this program.**
4Ø5-D5	**DAYS SUPPLY**	**R**	**Required for this program.**

CLAIM SEGMENT		*Segment MANDATORY for these transactions: B1, B2, and B3.*	
Field	**Field Name**	**Mandatory Situational**	**KENTUCKY MEDICAID VALUES SUPPORTED**
4Ø6-D6	**COMPOUND CODE**	**R**	**Required for this program.**
4Ø8-D8	**DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE**	**R**	**Required for this program.**
414-DE	**DATE PRESCRIPTION WRITTEN**	**R**	**Required for this program.**
415-DF	**NUMBER OF REFILLS AUTHORIZED**	**R**	**Required for this program.**
419-DJ	PRESCRIPTION ORIGIN CODE	S	
42Ø-DK	**SUBMISSION CLARIFICATION CODE**	**RW**	**Required when needed to provide additional information for coverage purposes.**
46Ø-ET	QUANTITY PRESCRIBED	S	
3Ø8-C8	**OTHER COVERAGE CODE**	**RW**	**Required when needed for COB.**
429-DT	**UNIT DOSE INDICATOR**	**RW**	**Required when needed to identify unit dose packaging.**
453-EJ	ORIGINALLY PRESCRIBED PRODUCT/SERVICE ID QUALIFIER	S	
445-EA	ORIGINALLY PRESCRIBED PRODUCT/SERVICE CODE	S	
446-EB	ORIGINALLY PRESCRIBED QUANTITY	S	
33Ø-CW	ALTERNATE ID	S	
454-EK	SCHEDULED PRESCRIPTION ID NUMBER	S	
6ØØ-28	**UNIT OF MEASURE**	**R**	**Required for this program.**
418-DI	**LEVEL OF SERVICE**	**RW**	**Required when overriding for an emergency fill.** **Ø3 = Emergency**
461-EU	**PRIOR AUTHORIZATION TYPE CODE**	**RW**	**Required when need to provide additional information for coverage purposes.** **4=exemption from copay for all claims associated with a compound except for the first claim.**
462-EV	PRIOR AUTHORIZATION NUMBER SUBMITTED	S	
463-EW	INTERMEDIARY AUTHORIZATION TYPE ID	S	
464-EX	INTERMEDIARY AUTHORIZATION ID	S	
343-HD	**DISPENSING STATUS**	**RW**	**Required when submitting a partial fill or the completion of a partial fill.**
344-HF	**QUANTITY INTENDED TO BE DISPENSED**	**RW**	**Required when submitting a partial fill or the completion of a partial fill.**
345-HG	**DAYS SUPPLY INTENDED TO BE DISPENSED**	**RW**	**Required when submitting a partial fill or the completion of a partial fill.**

PRICING SEGMENT		*Segment MANDATORY for these transactions: B1 and B3.*	
Field	**Field Name**	**Mandatory Situational**	**KENTUCKY MEDICAID VALUES SUPPORTED**
111-AM	**SEGMENT IDENTIFICATION**	**M**	**11 = Pricing Segment**
4Ø9-D9	**INGREDIENT COST SUBMITTED**	**R**	**Required for this program. Zero is a valid value.**
412-DC	**DISPENSING FEE SUBMITTED**	**R**	**Required if its value has an effect on the Gross Amount Due (43Ø-DU) calculation. Zero is a valid value.**
477-BE	PROFESSIONAL SERVICE FEE SUBMITTED	S	
433-DX	PATIENT PAID AMOUNT SUBMITTED	S	Do not submit any value other than zero in this field.
438-E3	INCENTIVE AMOUNT SUBMITTED	S	
478-H7	OTHER AMOUNT CLAIMED SUBMITTED COUNT	S***R*** Max = 3	
479-H8	OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER	S***R*** Max = 3	
48Ø-H9	OTHER AMOUNT CLAIMED SUBMITTED	R***R*** Max = 3	
481-HA	FLAT SALES TAX AMOUNT SUBMITTED	S	
482-GE	PERCENTAGE SALES TAX AMOUNT SUBMITTED	S	
483-HE	PERCENTAGE SALES TAX RATE SUBMITTED	S	
484-JE	PERCENTAGE SALES TAX BASIS SUBMITTED	S	
426-DQ	**USUAL AND CUSTOMARY CHARGE**	**R**	**Required for this program.**
43Ø-DU	**GROSS AMOUNT DUE**	**R**	**Effective January 4, 2005 this field will be used in "lesser of" pricing.**
423-DN	BASIS OF COST DETERMINATION	S	

PHARMACY PROVIDER SEGMENT	*Segment NOT REQUIRED at this time; fields intentionally not listed. Possible future use.*

PRESCRIBER SEGMENT		*Segment REQUIRED for these transactions: B1 and B3.*	
Field	**Field Name**	**Mandatory Situational**	**KENTUCKY MEDICAID VALUES SUPPORTED**
111-AM	**SEGMENT IDENTIFICATION**	**M**	**Ø3 = Prescriber Segment**
466-EZ	**PRESCRIBER ID QUALIFIER**	**R**	**08 = State License Number**
411-DB	**PRESCRIBER ID**	**R**	**State License Number (prescriber specific)**
467-1E	PRESCRIBER LOCATION CODE	S	
427-DR	PRESCRIBER LAST NAME	S	
498-PM	PRESCRIBER PHONE NUMBER	S	
468-2E	PRIMARY CARE PROVIDER ID QUALIFIER	S	
421-DL	PRIMARY CARE PROVIDER ID	S	
469-H5	PRIMARY CARE PROVIDER LOCATION CODE	S	

PRESCRIBER SEGMENT		*Segment REQUIRED for these transactions: B1 and B3.*	
Field	**Field Name**	**Mandatory Situational**	**KENTUCKY MEDICAID VALUES SUPPORTED**
47Ø-4E	PRIMARY CARE PROVIDER LAST NAME	S	

COB SEGMENT		*Segment REQUIRED for these transactions: B1 and B3 if there is OTHER PAYER information.*	
Field	**Field Name**	**Mandatory Situational**	**KENTUCKY MEDICAID VALUES SUPPORTED**
111-AM	**SEGMENT IDENTIFICATION**	**M**	**Ø5 = Coordination of Benefits/ Other Payments Segment**
337-4C	**COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT**	**M Max = 3**	
338-5C	**OTHER PAYER COVERAGE TYPE**	**M***R*** Max = 3**	
339-6C	**OTHER PAYER ID QUALIFIER**	**S***R*** Max = 3**	Not required at this time.
34Ø-7C	**OTHER PAYER ID**	**S***R*** Max = 3**	Not required at this time.
443-E8	**OTHER PAYER DATE**	**R***R*** Max = 3**	**Required for this program.**
341-HB	**OTHER PAYER AMOUNT PAID COUNT**	**RW**	**Required when submitting Other Payer Amount Paid.**
342-HC	**OTHER PAYER AMOUNT PAID QUALIFIER**	**RW***R*** Max = 3**	**Required when submitting for this program.**
431-DV	**OTHER PAYER AMOUNT PAID**	**RW***R*** Max = 3**	**Required for this program.**
471-5E	**OTHER PAYER REJECT COUNT**	**RW**	**Required when the primary has rejected the claim.**
472-6E	**OTHER PAYER REJECT CODE**	**RW**	**Required when the primary has rejected the claim.**

WORKERS' COMP SEGMENT	***Segment NOT REQUIRED; fields intentionally not listed.***

DUR/ PPS SEGMENT		*Segment REQUIRED for these transactions: B1 and B3 if there is DUR information.*	
Field	**Field Name**	**Mandatory Situational**	**KENTUCKY MEDICAID VALUES SUPPORTED**
111-AM	**SEGMENT IDENTIFICATION**	**M**	**Ø8 = DUR/ PPS Segment**
473-7E	**DUR/PPS CODE COUNTER**	**RW***R Max = 9**	**Required when needed to communicate DUR information.**
439-E4	**REASON FOR SERVICE CODE**	**RW***R Max = 9**	**Required when needed to communicate DUR information. *See "Pro-DUR" section in Provider Manual.***
44Ø-E5	**PROFESSIONAL SERVICE CODE**	**RW***R Max = 9**	**Required when needed to communicate DUR information. *See "Pro-DUR" section in Provider Manual.***
441-E6	**RESULT OF SERVICE CODE**	**RW***R Max = 9**	**Required when needed to communicate DUR information. *See "Pro-DUR" section in***

DUR/ PPS SEGMENT		*Segment REQUIRED for these transactions: B1 and B3 if there is DUR information.*	
Field	**Field Name**	**Mandatory Situational**	**KENTUCKY MEDICAID VALUES SUPPORTED**
			Provider Manual.
474-8E	**DUR/PPS LEVEL OF EFFORT**	**RW***R Max = 9**	**Required when needed to communicate DUR information.** ***See "Pro-DUR" section in Provider Manual.***
475-J9	DUR CO-AGENT ID QUALIFIER	S***R Max = 9	
476-H6	DUR CO-AGENT ID	S***R Max = 9	

COUPON SEGMENT	***Segment NOT REQUIRED at this time; fields intentionally not listed. Possible future use.***

COMPOUND SEGMENT		***Segment will be required on/ about February 1, 2005. Providers will be notified.***	
Field	**Field Name**	**Mandatory Situational**	**KENTUCKY MEDICAID VALUES SUPPORTED**
111-AM	**SEGMENT IDENTIFICATION**	**M**	**10 = Compound Segment**
450-EF	**COMPOUND DOSAGE FORM DESCRIPTION CODE**	**M**	
451-EG	**COMPOUND DISPENSING UNIT FORM INDICATOR**	**M**	
452-EH	**COMPOUND ROUTE OF ADMINISTRATION**	**M**	
447-EC	**COMPOUND INGREDIENT COMPONENT COUNT**	**M**	Maximum of 25 iterations
488-RE	**COMPOUND PRODUCT ID QUALIFIER**	**M***R*****	
489-TE	**COMPOUND PRODUCT ID**	**M***R*****	
448-ED	**COMPOUND INGREDIENT QUANTITY**	**M***R*****	
449-EE	**COMPOUND INGREDIENT DRUG COST**	**R***R*****	**Required for this program.**
49Ø-UE	COMPOUND INGREDIENT BASIS OF COST DETERMINATION	S***R***	

PRIOR AUTHORIZATION SEGMENT	***Segment NOT REQUIRED at this time; fields intentionally not listed. Future use. Specifications will be provided at a later date.***

CLINICAL SEGMENT		*Segment REQUIRED for these transactions: B1 and B3 if designated clinical information is needed for drug coverage consideration.*	
Field	**Field Name**	**Mandatory Situational**	**KENTUCKY MEDICAID VALUES SUPPORTED**
111-AM	**SEGMENT IDENTIFICATION**	**M**	**13 = Clinical Segment**
491-VE	**DIAGNOSIS CODE COUNT**	**S Max = 5**	
492-WE	**DIAGNOSIS CODE QUALIFIER**	**S***R*** Max = 5**	**01 = International Classification of Diseases (ICD9)**
424-DO	**DIAGNOSIS CODE**	**S***R*** Max = 5**	**All decimal points are explicit**
493-XE	CLINICAL INFORMATION COUNTER	S	
494-ZE	MEASUREMENT DATE	S	
495-H1	MEASUREMENT TIME	S	
496-H2	MEASUREMENT DIMENSION	S	
497-H3	MEASUREMENT UNIT	S	
499-H4	MEASUREMENT VALUE	S	

- **Response segment and field requirements:**
- **PAID (or DUPLICATE OF PAID) Response:**

TRANSACTION HEADER SEGMENT		***Segment MANDATORY for all transactions.***	
Field	**Field Name**	**Mandatory Situational**	**KENTUCKY MEDICAID VALUES SUPPORTED**
1Ø2-A2	VERSION/RELEASE NUMBER	M	Same value as in request billing
1Ø3-A3	TRANSACTION CODE	M	Same value as in request billing
1Ø9-A9	TRANSACTION COUNT	M	Same value as in request billing
5Ø1-F1	HEADER RESPONSE STATUS	M	A
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	M	Same value as in request billing
2Ø1-B1	SERVICE PROVIDER ID	M	Same value as in request billing
4Ø1-D1	DATE OF SERVICE	M	Same value as in request billing

RESPONSE MESSAGE SEGMENT		***Segment SITUATIONAL.***	
Field	**Field Name**	**Mandatory Situational**	**KENTUCKY MEDICAID VALUES SUPPORTED**
111-AM	SEGMENT IDENTIFICATION	M	2Ø = Response Message Segment
5Ø4-F4	MESSAGE	S	

RESPONSE INSURANCE SEGMENT		***Segment SITUATIONAL.***	
Field	**Field Name**	**Mandatory Situational**	**KENTUCKY MEDICAID VALUES SUPPORTED**
111-AM	SEGMENT IDENTIFICATION	M	25 = Response Insurance Segment
3Ø1-C1	GROUP ID	S	
524-FO	PLAN ID	S	
545-2F	NETWORK REIMBURSEMENT ID	S	
568-J7	PAYER ID QUALIFIER	S	
569-J8	PAYER ID	S	

RESPONSE STATUS SEGMENT		***Segment SITUATIONAL.***	
Field	**Field Name**	**Mandatory Situational**	**KENTUCKY MEDICAID VALUES SUPPORTED**
111-AM	SEGMENT IDENTIFICATION	M	21 = Response Status Segment
112-AN	TRANSACTION RESPONSE STATUS	M	P = Paid D = Duplicate
5Ø3-F3	AUTHORIZATION NUMBER	S	Returned when needed to identify the transaction.
51Ø-FA	REJECT COUNT	S	
511-FB	REJECT CODE	S***R***	
546-4F	REJECT FIELD OCCURRENCE INDICATOR	S***R***	
547-5F	APPROVED MESSAGE CODE COUNT	S	
548-6F	APPROVED MESSAGE CODE	S***R***	

RESPONSE STATUS SEGMENT		*Segment SITUATIONAL.*	
Field	**Field Name**	**Mandatory Situational**	**KENTUCKY MEDICAID VALUES SUPPORTED**
526-FQ	ADDITIONAL MESSAGE INFORMATION	S	
549-7F	HELP DESK PHONE NUMBER QUALIFIER	S	
55Ø-8F	HELP DESK PHONE NUMBER	S	

RESPONSE CLAIM SEGMENT		*Segment SITUATIONAL.*	
Field	**Field Name**	**Mandatory Situational**	**KENTUCKY MEDICAID VALUES SUPPORTED**
111-AM	SEGMENT IDENTIFICATION	M	22 = Response Claim Segment
455-EM	PRESCRIPTION/ SERVICE REFERNCE NUMBER QUALIFIER	M	1 = Rx billing
4Ø2-D2	PRESCRIPTION/ SERVICE REFERNCE NUMBER	M	
551-9F	PREFERRED PRODUCT COUNT	S	
552-AP	PREFERRED PRODUCT ID QUALIFIER	S***R***	
553-AR	PREFERRED PRODUCT ID	S***R***	
554-AS	PREFERRED PRODUCT INCENTIVE	S***R***	
555-AT	PREFERRED PRODUCT COPAY INCENTIVE	S***R***	
556-AU	PREFERRED PRODUCT DESCRIPTION	S***R***	

RESPONSE PRICING SEGMENT		*Segment SITUATIONAL.*	
Field	**Field Name**	**Mandatory Situational**	**KENTUCKY MEDICAID VALUES SUPPORTED**
111-AM	SEGMENT IDENTIFICATION	M	23 = Response Pricing Segment
5Ø5-F5	PATIENT PAY AMOUNT	S	Returned if the processor determines that the patient has payment responsibility for part/all of the claim.
5Ø6-F6	INGREDIENT COST PAID	S	Required if this value is used to arrive at the final reimbursement.
5Ø7-F7	DISPENSING FEE PAID	S	Required if this value is used to arrive at the final reimbursement.
557-AV	TAX EXEMPT INDICATOR	S	
558-AW	FLAT SALES TAX AMOUNT PAID	S	
559-AX	PERCENTAGE SALES TAX AMOUNT PAID	S	
56Ø-AY	PERCENTAGE SALES TAX RATE PAID	S	
561-AZ	PERCENTAGE SALES TAX BASIS PAID	S	
521-FL	INCENTIVE AMOUNT PAID	S	
562-J1	PREOFESSIONAL SERVICE FEE PAID	S	
563-J2	OTHER AMOUNT PAID COUNT	S	
564-J3	OTHER AMOUNT PAID QUALIFIER	SW***R***	
565-J4	OTHER AMOUNT PAID	SW***R***	
566-J5	OTHER PAYER AMOUNT RECOGNIZED	S	
5Ø9-F9	TOTAL AMOUNT PAID	S	

RESPONSE PRICING SEGMENT		*Segment SITUATIONAL.*	
Field	**Field Name**	**Mandatory Situational**	**KENTUCKY MEDICAID VALUES SUPPORTED**
522-FM	BASIS OF REIMBURSEMENT DETERMINATION	S	
523-FN	AMOUNT ATTRIBUTED TO SALES TAX	S	
512-FC	ACCUMULATED DEDUCTIBLE AMOUNT	S	
513-FD	REMAINING DEDUCTIBLE AMOUNT	S	
514-FE	REMAINING BENEFIT AMOUNT	S	
517-FH	AMOUNT APPLIED TO PERIODIC DEDUCTIBLE	S	
518-FI	AMOUNT OF COPAY/CO-INSURANCE	S	
519-FJ	AMOUNT ATTRIBUTED TO PRODUCT SELECTION	S	
52Ø-FK	AMOUNT EXCEEDING PERIODIC BENEFIT MAXIMUM	S	
346-HH	BASIS OF CALCULATION – DISPENSING FEE	S	
347-HJ	BASIS OF CALCULATION – COPAY	S	
348-HK	BASIS OF CALCULATION – FLAT SALES TAX	S	
349-HM	BASIS OF CALCULATION – PERCENTAGE SALES TAX	S	

RESPONSE DUR/ PPS SEGMENT		*Segment SITUATIONAL.*	
Field	**Field Name**	**Mandatory Situational**	**KENTUCKY MEDICAID VALUES SUPPORTED**
111-AM	SEGMENT IDENTIFICATION	M	24 = Response DUR/ PPS Segment
567-J6	DUR/ PPS RESPONSE CODE COUNTER	S***R***	
439-E4	REASON FOR SERVICE CODE	S***R***	*See Provider Manual for allowed values*. <client>
528-FS	CLINICAL SIGNIFICANCE CODE	S***R***	
529-FT	OTHER PHARMACY INDICATOR	S***R***	Ø = Not specified 1 = Your pharmacy 2 = Other pharmacy in same chain 3 = Other pharmacy
53Ø-FU	PREVIOUS DATE OF FILL	S***R***	
531-FV	QUANTITY OF PREVIOUS FILL	S***R***	
532-FW	DATABASE INDICATOR	S***R***	
533-FX	OTHER PRESCRIBER INDICATOR	S***R***	Ø = Not specified 1 = Same prescriber 2 = Other prescriber
544-FY	DUR FREE TEXT MESSAGE	S***R***	Required when text is needed for additional clarification.

RESPONSE PRIOR AUTHORIZATION SEGMENT	***Segment NOT REQUIRED at this time; fields intentionally not listed. Future use. Specifications will be provided at a later date.***

- **Response segment and field requirements:**

- **REJECT Response:**

TRANSACTION HEADER SEGMENT		***Segment MANDATORY for all transactions.***	
Field	**Field Name**	**Mandatory Situational**	**KENTUCKY MEDICAID VALUES SUPPORTED**
1Ø2-A2	VERSION/RELEASE NUMBER	M	Same value as in request billing
1Ø3-A3	TRANSACTION CODE	M	Same value as in request billing
1Ø9-A9	TRANSACTION COUNT	M	Same value as in request billing
5Ø1-F1	HEADER RESPONSE STATUS	M	R
2Ø2-B2	SERVICE PROVIDER ID QUALIFIER	M	Same value as in request billing
2Ø1-B1	SERVICE PROVIDER ID	M	Same value as in request billing
4Ø1-D1	DATE OF SERVICE	M	Same value as in request billing

RESPONSE MESSAGE SEGMENT		***Segment OPTIONAL.***	
Field	**Field Name**	**Mandatory Situational**	**KENTUCKY MEDICAID VALUES SUPPORTED**
111-AM	SEGMENT IDENTIFICATION	M	2Ø = Response Message Segment
5Ø4-F4	MESSAGE	S	Required if text is needed for clarification or detail.

RESPONSE STATUS SEGMENT		***Segment OPTIONAL.***	
Field	**Field Name**	**Mandatory Situational**	**KENTUCKY MEDICAID VALUES SUPPORTED**
111-AM	SEGMENT IDENTIFICATION	M	21 = Response Status Segment
112-AN	TRANSACTION RESPONSE STATUS	M	R = Rejected
5Ø3-F3	AUTHORIZATION NUMBER	S	Returned if needed to identify the transaction
51Ø-FA	REJECT COUNT	S	
511-FB	REJECT CODE	S***R***	*See Provider Manual for list of applicable error codes.*
546-4F	REJECT FIELD OCCURRENCE INDICATOR	S***R***	
547-5F	APPROVED MESSAGE CODE COUNT	S	
548-6F	APPROVED MESSAGE CODE	S***R***	
526-FQ	ADDITIONAL MESSAGE INFORMATION	S	
549-7F	HELP DESK PHONE NUMBER QUALIFIER	S	
55Ø-8F	HELP DESK PHONE NUMBER	S	

Appendix C: MAC Forms

First Health
Services Corporation

Request for the Kentucky Maximum Allowable Cost (MAC) List

Provider is granted access to the Kentucky Medicaid Maximum Allowable Cost (MAC) list for the sole purpose of assisting Provider in submitting claims to Kentucky Medicaid and understanding the Kentucky Medicaid program's claims reimbursement.

Provider shall not reproduce, distribute, or make any other use of the Kentucky Medicaid MAC list other than as specified herein. In order to receive the Kentucky Medicaid MAC list, Provider must indicate acceptance of these Confidentiality Terms and Conditions of Use by completing this form and mailing to First Health Services.

By doing so, Provider expressly agrees to be bound by these Confidentiality Terms and Conditions of Use and acknowledges that Provider may be held liable for any breach thereof.

Upon receipt of this form, the Maximum Allowable Cost list will be mailed to the provider.

Mail completed form to the address below.

First Health Services Corp.
4300 Cox Road
Glen Allen, VA 23060
Attn: Rebate/MAC Department

Provider Name:_____

Provider Medicaid ID Number:_____

Provider Phone Number:_____

Pharmacists' Name:_____

Pharmacists' Signature:_____

First Health Services Corporation

MAC PRICE INQUIRIES AND RESEARCH REQUEST FORM

By submitting this form, I am requesting that First Health Services research the Kentucky MAC List price of the drug listed on this form and consider a price modification as described in the "Comments" section below.

DATE: _____

PROVIDER NAME*: _____

PROVIDER MEDICAID NUMBER*:_____

PROVIDER PHONE*: ☐☐☐ – ☐☐☐ – ☐☐☐☐

PROVIDER FAX*: ☐☐☐ – ☐☐☐ – ☐☐☐☐

PROVIDER NABP #: ☐☐☐☐☐☐☐

PROVIDER CONTACT*: **_____**

DRUG NAME, STRENGTH
And DOSAGE FORM*:_____

NDC#*: ☐☐☐☐☐–☐☐☐☐–☐☐

RECIPIENT ID #_____RX#_____
PRICE*: _____

COMMENTS:

_____

_____

Return this form to First Health Services: Attn: REBATE/MAC DEPARTMENT
FAX: 804-217-7911
E-MAIL: Rebate@fhsc.com

RESPONSE DATE: _____

RESPONSE: _____

***REQUIRED FIELD (RED)**

Appendix D: Prior Authorization (PA) Forms

First Health
Services Corporation

Drug Prior Authorization Request Form (MAP-82101, revised 10/18/04)

Submitted by: [ ] Prescriber [ ] Pharmacy

Approval does not ensure eligibility. Please verify Medicaid eligibility before completing this form.

FAX to **800-365-8835** (toll free)

For **URGENT** Requests Only, FAX to **800-421-9064** (toll free)
For **NURSING FACILITY** Requests Only, FAX to **800-453-2273** (toll free)

MAIL to PA Unit, 14955 Heathrow Forest Pkwy. Houston, TX 77032
Put return address below:

_____

REQUEST TYPE (please check): ☐ **PRIOR AUTHORIZATION** ☐ **MEDICARE PART B OVERRIDE** ☐ **QUANTITY LIMIT OVERRIDE**
☐ **OTHER** _____

RECIPIENT NAME	**MAID # (10 digits)**	**DATE OF BIRTH**
	_ _ _ _ _ _ _ _ _ _	

	PRESCRIBER Information	**PHARMACY Information**
Name		
Phone #		
Fax #		
State License# (Not DEA# or Any other #)		

	Drug Requested (Use separate form to request more than 4 drugs.)	**Dosage Form**	**Strength**	**Quantity**	**Directions for use**	**Start Date for this PA**	**National Drug Code (if known)**
1							
2							
3							
4							

HAS THE REQUESTED DRUG BEEN PRIOR AUTHORIZED PREVIOUSLY? [ ] YES [ ] NO [ ] UNKNOWN

PERTINENT DIAGNOSES _____

CURRENT MEDICATIONS _____

_____

MEDICAL JUSTIFICATION (including drugs already tried)_____

_____

_____

MEDICARE PART B REQUEST REASON (PLEASE CHECK ONE): (A copy of the Medicare EOB denying coverage must accompany each request)

☐ RECIPIENT IS NOT MEDICARE PART B ELIGIBLE

☐ OTHER (PLEASE EXPLAIN ABOVE)

☐ RECIPIENT IS TAKING THE MEDICATION FOR AN INDICATION THAT IS NOT COVERED BY MEDICARE

☐ DRUG DOES NOT MEET MEDICARE COVERAGE CRITERIA

	LEAVE THIS SECTION BLANK
DRUG #1	
DRUG #2	
DRUG #3	
DRUG #4	

First Health Services Corporation

PPI and H2 BLOCKER Request Form

(MAP-82101, revised 10/18/04)

Submitted by: [ ] Prescriber [ ] Pharmacy

Approval does not ensure eligibility. Please verify Medicaid eligibility before completing this form.

FAX to **800-365-8835** (toll free)

For **URGENT** Requests Only, FAX to **800-421-9064** (toll free)

For **NURSING FACILITY** Requests Only, FAX to **800-453-2273** (toll free)

MAIL to PA Unit, 14955 Heathrow Forest Pkwy. Houston, TX 77032
Put return address below:

_____

RECIPIENT NAME	MAID # (10 digits)	DATE OF BIRTH
	_ _ _ _ _ _ _ _ _	

	PRESCRIBER Information	PHARMACY Information
Name		
Phone #		
Fax #		
State License# (Not DEA# or Any other #)		

	Name of Drug Requested	Dosage Form	Strength	Quantity	Directions for use	Start Date for this PA	National Drug Code (if known)
1							

YES	NO	Unknown	
[ ]	[ ]	[ ]	is the request for brand name only (if generic is available)? If yes, prescriber must handwrite *Brand Necessary* & sign beside it: _____
[ ]	[ ]	[ ]	Has the requested drug been prior authorized previously?
[ ]	[ ]	[ ]	Has endoscopy or an esophagram been done? Give date of exam & results: _____ _____
[ ]	[ ]	[ ]	For PPI requests: Is the request for initial or new treatment with a PPI?
[ ]	[ ]	[ ]	For PPI requests: Has the recipient been treated for more than 12 weeks with PPIs during the past 6 months?

DIAGNOSIS (check one)

[ ] Barrett's esophagitis
[ ] Duodenal ulcer, acute or recurring
[ ] Esophageal stricture
[ ] Gastric cancer, current or previous
[ ] Gastric Ulcer, acute or recurring
[ ] GERD (Gastroesophageal Reflux Disease)
[ ] GERD grade III-V, continuing symptomatic
[ ] GERD , atypical with chronic laryngitis, hoarseness, or cough due to reflux
[ ] *Heliobacter pylori* eradication protocol
[ ] NSAID gastropathy
[ ] Scharzki's ring
[ ] Zollinger-Ellison syndrome
[ ] Other (specify) _____

PPI or H2 Blocker Therapy (List all PPIs and H2 blockers used in the past 3 months	Dosage Form	Strength	Directions for Use	Date treatment started	Date treatment ended

CURRENT MEDICATIONS _____

MEDICAL JUSTIFICATION (including drugs already tried)_____

_____

	LEAVE THIS SECTION BLANK

First Health
Services Corporation

BRAND NAME
DRUG REQUEST FORM
(MAP-82101, revised 10/18/04)

Approval does not ensure eligibility. Please verify Medicaid eligibility before completing this form.

FAX to **800-365-8835** (toll free)

For **URGENT** Requests Only, FAX to **800-421-9064** (toll free)

For **NURSING FACILITY** Requests Only, FAX to **800-453-2273** (toll free)

MAIL to PA Unit, 14955 Heathrow Forest Pkwy. Houston, TX 77032
Put return address below:

_____

Use this form to request a brand name drug when generic forms of the drug are available. Please provide medical justification why the individual can not be appropriately treated with the generic form of the drug.

RECIPIENT NAME	MAID #	DATE OF BIRTH
	_ _ _ _ _ _ _ _ _	

	PRESCRIBER Information	PHARMACY Information
Name		
Phone #		
Fax #		
State License # (Not DEA# or Any other #)		

	Brand Name Drug Requested (Use separate form to request more than 2 drugs.)	Dosage Form	Strength	Quantity	Directions for use	Start Date for this PA
1						
2						

	Has patient recently been treated with generic forms of the requested brand name drug? Circle yes or no. Specify dosage and length of therapy with generic forms.	Hand write "Brand Medically Necessary"	Prescriber Signature
1	Yes No		
2	Yes No		

HAS THE REQUESTED DRUG BEEN PRIOR AUTHORIZED PREVIOUSLY? [ ] YES [ ] NO [ ] UNKNOWN

PERTINENT DIAGNOSES _____

CURRENT MEDICATIONS _____

_____

MEDICAL JUSTIFICATION (Indicate why the individual's medical condition cannot be adequately treated with generic forms of the drug. Provide any appropriate laboratory tests, blood levels, dates generic drugs prescribed by current/previous providers, or any other medical documents to support the request for the brand name drug.)

***If the patient had an adverse response to the generic form of the drug, have you submitted a MedWatch form to the FDA? If yes, please include a copy with this form.

_____

_____

_____

	LEAVE THIS SECTION BLANK
DRUG #1	
DRUG #2	